THE RECOVERY KERNEL

How to Navigate the Recovery Kernel

For People Recovering from Nicotine

Cigarettes, vapes, nicotine pouches, snus, chewing tobacco, hookah, cigars, and pipes. A step-by-step route: what to read, in what order, and what outcome the Kernel projects if you follow it.

> **HARM REDUCTION RESOURCE — NOT MEDICAL ADVICE.** Nicotine withdrawal is not medically dangerous, but the medicines that make quitting work involve a prescriber, and some have real cautions. **Bupropion lowers the seizure threshold:** the Kernel says it is not for people with a seizure history, an eating disorder, or current alcohol withdrawal. **Get emergency care for chest pain, sudden breathlessness, or the sudden onset of severe chest or lung symptoms in a vaper.** If you take a psychiatric medication, tell your prescriber before you quit (see Step 0).
>
> The mood dip after quitting can be real. Crisis: call or text 988 · Free quit support: 1-800-QUIT-NOW · SAMHSA: 1-800-662-4357

1. Before you start

This is a route through the Recovery Kernel for people who want to stop nicotine in any form, and for the people supporting them. The Kernel opens with the scale: 1.3 billion people use tobacco, about 8 million die of it each year, and more people are dependent on nicotine than on every other substance in the series combined. Yet it says nicotine is one of the most treatable addictions in medicine, with several effective medicines, clear genomic predictors of response, and cessation rates that rise sharply with the right combination. The gap it names: people who would never treat opioid withdrawal without medicine try nicotine withdrawal on willpower, fail again and again, and decide they cannot quit. The mechanism: nicotine reaches the brain in about ten seconds, faster than intravenous cocaine, and the dopamine release through the α4β2 nicotinic receptor rewires the reward system. Six rules follow.

- **Medication is the foundation.** The Kernel says attempting cessation without it is statistically likely to fail, and not because of weak commitment.
- **Nicotine is the addiction, whatever the delivery.** Cigarettes, vapes, pouches, snus, chew, and hookah differ in physical harm, not in dependence.
- **Tobacco was often treating something.** Depression, ADHD, anxiety, and worse. The Kernel says to have that managed before the tobacco is removed.
- **A craving peaks in 3 to 5 minutes.** You only have to outlast it, and you have tools to do so.
- **One cigarette restarts the conditioning.** The Kernel calls this pharmacological reality, not perfectionism.
- **Do not wait for test results to start.** The genome refines the medication choice (Main Book, Quick-Start Step 3; Supp. Ch. 5, Step 1b), but the medical steps come first.

How chapters are cited. "Main Book" is the Recovery Kernel Main Book (Second Edition, Centurian). "Compendium" is the Complete Protocol Compendium. "Supp. Ch. N" is chapter N of the Supplemental Book. The core chapter is Chapter 22 (How to Recover from Nicotine), with Case 13 in Chapter 2 as its case study. Section numbers (§) refer to sections inside those chapters.

> **A note on protocol numbers.** Supplemental Chapter 22 cites Compendium protocols by number, and some numbers do not match the Compendium as printed. It sends the quit-date phase to Protocols 01 and 05 (printed: Emergency Triage and Digital Detox), the foundation phase to Protocol 09 (printed: The Gut-Brain Axis), and the natural-architecture phase to Protocol 03 (printed: Sonic Architecture; exercise is Protocol 19) and Protocol 04 (printed: Meeting Alternatives). Sleep (Protocol 17) and neuroplasticity (Protocol 07) match. Its GLP-1 reference matches Protocol 44 (GLP-1 Receptor Agonists in Recovery). This guide cites each protocol by its printed title. If a number and a title disagree, follow the title.
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> For nicotine replacement, a returning craving is often misread as “the patch isn’t working,” when combination therapy (a patch for baseline, gum for the wave) is usually the actual fix.
>
> Redosing is not the only version of this. Watching peers in a treatment setting negotiate a relapse, getting confident advice from someone untrained in your specific situation, or noticing a prescriber treat a prescribed substance more casually than an illicit one can all trigger the same pattern: a felt doubt read as “the plan must be wrong,” answered by abandoning it. See **The Commandeering Map**, a companion to this series, for the fuller pattern, including how it can differ by genetic profile and what helps when practice-based resistance alone is not enough.

2. The route at a glance

Steps 0 and 1 come first. Steps 2 to 4 can run at the same time. Steps 5 to 9 overlap and are the work of the first year. Step 10 is everything after. "P" means Compendium Protocol; "C" means Centurian Paper.

Step	When	What you do	Turn to
0	Day 0	Triage: medication cautions, psychiatric medicines, vaping-lung symptoms, mood.	Supp. Ch. 22 §1.3, §3.1 Main Book, Quick-Start Step 1 Compendium P01
1	Days 0–14	Choose your plan with a prescriber: medicine, product, quit date or reduction.	Supp. Ch. 22 §3 Compendium P44
2	Weeks 1–4	Read the Main Book in order.	Main Book: Who This Book Is For, Quick-Start, Part One (Ch. 1–5) Supp. Ch. 2, 3
3	Weeks 1–4	Order 30× whole-genome sequencing. CHRNA5 and CYP2A6 are the priority.	Supp. Ch. 5 Step 1 Supp. Ch. 22 §2 Compendium P06
4	Weeks 2–6	Resolve your profile. Work out which of the five functions nicotine served.	Supp. Ch. 5 Steps 2–3, 6 Supp. Ch. 22 §1.3, §2, §6

Step	When	What you do	Turn to
5	Quit date, Weeks 0–12	Quit date to week 12: withdrawal, the craving interrupt, and the triggers.	Supp. Ch. 22 §3.2, §5, §7 Compendium P01, P05
6	Week 1 to Month 6	Build the biological foundation: methylation, choline, NAC, dopamine, sleep.	Supp. Ch. 22 §4 Supp. Ch. 5 Phase One Compendium P07, P17
7	Before quit day, ongoing	Treat the underlying condition: depression, ADHD, anxiety, and more.	Supp. Ch. 22 §1.3, §7 Supp. Ch. 39 Compendium P13
8	Weeks 1–12, then ongoing	Build the natural architecture that replaces the five functions.	Supp. Ch. 22 §6 C-28; Compendium P19, P29
9	From week 1	Body recovery: lungs, heart, weight, and screening.	Supp. Ch. 22 §4.4, §4.6, §8 Compendium P19
10	Months 3+, Year 1 to 10	The long game: the 12-month risk window, identity, and stewardship.	Supp. Ch. 22 §7 Supp. Ch. 44, 6, 38 Compendium C-28, P24, P25

3. The route, step by step

Step 0 — Triage (Day 0, before anything)

Three checks. Medication cautions: bupropion is not for a seizure history, an eating disorder, or current alcohol withdrawal (Kernel). Mood and psychiatric history: the Kernel says people with schizophrenia (70 to 90 percent smoke), bipolar disorder (40 to 70), ADHD (35 to 40), depression (40 to 60), and alcohol use disorder (70 to 80) use nicotine for a real therapeutic function, and that cessation without psychiatric support in these groups routinely fails, so plan for that first. Vaping: any sudden lung symptoms in a vaper need medical care (the Kernel names EVALI, a lung injury linked to vitamin E acetate in some products).

> **A caution this guide adds (not in the Kernel).** Tobacco smoke speeds the liver's clearance of some drugs. If you take clozapine or olanzapine, or theophylline, their levels can rise after you quit, so tell your prescriber before your quit date so the dose can be monitored. Caffeine also hits harder after quitting, since smoke had been speeding its clearance. See the companion caffeine guide.

Turn to: Supp. Ch. 22 §1.3 (the psychiatric comorbidity pattern) and §3.1 (the medication options and their cautions). Main Book, Quick-Start Boot Sequence, Step 1. Compendium Protocol 01, Emergency Triage, for an acute crisis state.

Step 1 — Choose your plan with a prescriber (Days 0–14)

The Kernel's medication ranking, with its own figures for how much each improves quit rates over placebo. Varenicline: a partial agonist at the α4β2 receptor that eases withdrawal and blunts reward from smoking. It calls it the most effective single medication (2 to 3 times placebo), strongest in CHRNA5 A carriers. The 2016 safety warning was revised, and it says current evidence shows no significantly raised psychiatric risk at standard doses. Vivid dreams are common. Combination nicotine replacement (a patch for the baseline plus gum or lozenge for spikes): 1.5 to 2.5 times placebo, better than a single product. Bupropion: 1.5 to 2 times placebo, especially with depression, and the Kernel's pick for a dopamine-driven Warrior. Varenicline plus a patch: the Kernel's highest-evidence approach (3 to 4 times placebo in some trials), and underused because providers present the medicines as either-or. It also names GLP-1 drugs (semaglutide, tirzepatide) as an emerging option, with reports of spontaneous cutting down and trials ongoing, and cytisine.

> **Cytisine: the status is changing.** The Kernel describes cytisine (Tabex, used for decades in Eastern Europe) as comparable to varenicline and available online. My check of current sources: cytisinicline, the form in US trials, was declined by the FDA in June 2026 for manufacturing and labeling issues, not for efficacy or safety, and the company plans to resubmit in late 2026. It is not approved in the US. Buying it online means an unregulated product, so ask your prescriber before you try it. Verify current status.

Timing and approach. The quit-date approach: pick a date one to two weeks out, start varenicline or bupropion a week before it (they need time to reach effective levels), and start nicotine replacement on the quit date. For people who cannot commit to a date, the gradual approach: cut cigarettes by half in four weeks, three quarters by week eight, and quit by week twelve, with replacement as a bridge. And using replacement or varenicline while still smoking is not failure. The Kernel calls it a harm-reduction phase that is linked to better ultimate quit rates. Medication should run at least 12 weeks.

Turn to: Supp. Ch. 22 §3 (the medication options; the cessation strategy framework). Compendium Protocol 44 (GLP-1 Receptor Agonists in Recovery). Supp. Ch. 38. Free support: Smokefree.gov, 1-800-QUIT-NOW (any primary care prescriber can prescribe varenicline and bupropion; ask by name).

Step 2 — Read the Main Book (Weeks 1–4)

Read it in order once you are settled. If you are overwhelmed, the Quick-Start Boot Sequence is designed to be read on its own. Read "Who This Book Is — and Is Not — For" first: it names situations where the supplement protocols need medical modification, including active psychosis, pregnancy, and severe liver disease.

Read in this order: Who This Book Is For → Quick-Start Boot Sequence → Part One: Ch. 1 (Why Willpower Isn't Enough, which is very much this chapter's argument), Ch. 2 (MTHFR), Ch. 3 (COMT), Ch. 4 (CYP450), Ch. 5 (When Systems Collide) → Part Two, the case files (Chapter 6). Ch. 8 (Oxytocin Protocol) is experimental and specialist-only. Ch. 9 (Epigenetic Playground) belongs to Steps 8 and 10. Appendix A and Appendix B are reference.

Then add: Supp. Ch. 2 (Clarity · Restoration · Manning), which includes Case 13, the nicotine case. Supp. Ch. 3 (The Addict Virgin Problem) recalibrates timelines. Supp. Ch. 1 (Why They Left You There) is optional reading for the shame.

Step 3 — Get your DNA (Weeks 1–4)

The Kernel's recommended route is 30× whole-genome sequencing, which returns a VCF file, a one-time asset you keep. A consumer SNP array is an acceptable start. A clinical pharmacogenomic panel adds clinical-grade CYP calls. Homocysteine, B12, and RBC folate are functional markers you can recheck quarterly.

The Kernel calls nicotine one of the best-characterized profiles in addiction medicine. **CHRNA5/CHRNA3/CHRNB4** (rs16969968 A allele): the strongest genetic predictor of dependence, with heavier smoking, harder quitting, higher lung cancer risk independent of amount, and a better response to varenicline. **CYP2A6** (nicotine clearance): slow metabolizers smoke less, get more per cigarette, find quitting easier, and have lower lung cancer risk; it guides patch dosing (a steady patch for slow, higher doses or more gum for fast). **COMT** (Val/Val Warrior is over-represented in heavy smokers), **MTHFR**, **DRD2** A1, and **SLC6A4** short/short (anxiety). Until results arrive, its free clues: more than a pack a day and harder to quit than peers suggest a CHRNA5 risk allele; fewer cigarettes but each one feels necessary suggests slow CYP2A6; smoking for focus with attention trouble suggests ADHD; anxiety relief that reverses into severe anxiety on quitting suggests SLC6A4; and severe mood drops on past quit attempts suggest MTHFR and dependence on tobacco's MAO-inhibiting effect.

> **Confirm what you are ordering.** Supp. Ch. 5 specifies 30× whole-genome sequencing with VCF output. "WGBS" more commonly names whole-genome bisulfite sequencing, a DNA-methylation assay that is not built to call variants such as MTHFR C677T. Ask the lab for a standard variant file (VCF).

Turn to: Supp. Ch. 5, Step 1. Supp. Ch. 22 §2 (the DNA testing panel for nicotine recovery; phenotyping without testing). Compendium Protocol 06, Phenotype Assessment. Main Book Ch. 2 and Ch. 3 self-assessments.

Step 4 — Resolve your profile (Weeks 2–6)

Write your profile down and carry key results on a card. The Kernel says smoking is not random, and that each cigarette served several functions at once: dopamine reward, anxiety relief, sharper focus, social belonging and ritual, and mood stabilization.

If your result is...	What changes	Source
CHRNA5 rs16969968 A allele	Heavier use, more dependence, harder quitting, higher lung cancer risk. Varenicline is your best single medicine, per the Kernel. Do not skip lung screening when eligible.	Supp. Ch. 22 §2, §3.1
CYP2A6 slow metabolizer	Nicotine clears slowly: fewer cigarettes, more per cigarette, somewhat easier quitting. A steady patch may suit you better than gum, and standard patches may over-deliver.	Supp. Ch. 22 §2, §3.1

If your result is...	What changes	Source
CYP2A6 fast metabolizer	Nicotine clears quickly. You may need higher patch doses and more frequent gum or lozenge.	Supp. Ch. 22 §3.1; Case 13
COMT Val/Val (Warrior)	Nicotine's dopamine was especially valued. The Kernel matches bupropion and dopamine support, and meets the intensity need through high-stimulation natural rewards.	Supp. Ch. 22 §2; Ch. 2 Case 13
MTHFR variants	Part of the mood was tobacco's MAO-inhibitor effect. 5-MTHF, psychiatric monitoring during quitting, and bupropion address it. Watch for depression.	Supp. Ch. 22 §2, §4.1; Main Book Ch. 2
DRD2 A1	Heavier smoking and more difficulty quitting because baseline reward is low. Build several reward sources.	Supp. Ch. 22 §2
SLC6A4 short/short	Nicotine's anxiety relief was especially compelling, and quitting raises anxiety. The Kernel suggests varenicline plus buspirone, and an SSRI or 5-MTHF for the serotonin side.	Supp. Ch. 22 §2

Turn to: Supp. Ch. 5, Steps 2, 3, and 6 (gene systems, combined profiles, profile template). Supp. Ch. 22 §1.3 (the psychiatric comorbidity pattern), §2, §6. Main Book Ch. 5 and Appendix A.

Step 5 — Quit date and the first twelve weeks (Weeks 0–12)

The Kernel's timeline: the first 72 hours are the most acute, week 1 is the hardest, and after week 2 the physical withdrawal has largely settled. What remains is behavioral and psychological. Combination replacement plus your chosen medicine runs the full course. Sleep is choppy at first, with vivid dreams as the receptors readjust, settling in two to four weeks. Receptor systems take roughly four to six weeks to recover substantially. The Kernel adds that the anxiety and low mood in early quitting are real withdrawal, not weakness.

The craving. Its most useful fact: a craving peaks in 3 to 5 minutes. Its trigger map: habit cues (morning coffee, after meals) that fire from conditioning, not need, so change the sequence (coffee somewhere else, a walk after eating); stress (nicotine was your stress response), so 4-7-8 breathing, magnesium, and L-theanine; social cues around other smokers, so tell people and keep replacement handy; and the "false permission" moment ("I deserve one"), which the Kernel says to name as rationalization by a depleted dopamine system, because one cigarette will restart the conditioning. The 3-minute interrupt: set a timer; five cycles of 4-7-8 breathing; use replacement rescue (gum or lozenge, which the Kernel says is the medicine working as intended); drink water; change your location; and wait for the timer to run out.

Turn to: Supp. Ch. 22 §3.2 (the cessation strategy framework), §5 (the nicotine craving: the trigger map; the 3-minute interrupt), and §7 (the protocol map). Compendium Protocol 01, Emergency Triage, and Protocol 05 (Digital Detox).

Step 6 — Build the biological foundation (Week 1 to Month 6)

The Kernel says three systems have to be rebuilt: the nicotinic receptors, the dopamine system, and the mood systems that tobacco's MAO inhibitors were supporting. Methylation: 5-MTHF, methylcobalamin, active B6, and magnesium glycinate. Receptor and cholinergic support: alpha-GPC, CDP-choline, lion's mane, and, cycled with breaks, huperzine-A. Dopamine and mood: tyrosine, NAC (evidence in cigarette cessation, begun on day 1), rhodiola, and 5-HTP (never with an SSRI). Sleep: melatonin, magnesium, glycine, and L-theanine. Lung repair: NAC, vitamins C and E, and EGCG, since smoking depletes vitamin C and glutathione. The dose tables are in the chapter and belong with your clinician. Run every addition past a pharmacist and an interaction checker (Drugs.com or Medscape).

Turn to: Supp. Ch. 22 §4.1 (methylation), §4.2 (nAChR system restoration), §4.3 (dopamine and mood recovery), §4.5 (sleep), §4.6 (pulmonary recovery). Supp. Ch. 5, Phase One. Main Book Ch. 2, §2.4–2.5. Compendium Protocol 07 (Neuroplasticity), Protocol 09 (The Gut-Brain Axis), Protocol 17 (The Nightly Restoration).

Step 7 — Treat the underlying condition (before quit day, then ongoing)

The Kernel's medium-term priority for anyone with a psychiatric condition: manage it without tobacco before the tobacco is removed. Depression: bupropion, 5-MTHF, exercise, and direct psychiatric care where it is clinical. ADHD: an evaluation and treatment, since nicotine sharpens the prefrontal cortex and treating ADHD is the sustainable replacement. Anxiety: buspirone, breathwork, and therapy. Schizophrenia and bipolar disorder: coordinate closely with the treating psychiatrist and the medication-clearance caution in Step 0. It says the cigarettes were doing something real, and that "cessation without psychiatric management almost invariably fails."

Turn to: Supp. Ch. 22 §1.3, §3.1, §7 (the psychiatric and underlying condition track). Supp. Ch. 39 (Complex Trauma and the Substance Connection). Compendium Protocol 13 (The Pharma Trap).

Step 8 — Build the natural architecture (Weeks 1–12, then ongoing)

The Kernel's functional replacement map. Dopamine and reward: daily aerobic exercise (30 to 45 minutes), cold showers, intervals, and something at the challenge-skill edge; it calls exercise the most impactful behavioral intervention beyond medication and says it doubled cessation success in some studies. Anxiety and stress relief: 4-7-8 breathing practiced until it is as automatic as reaching for a cigarette, 10 minutes morning and evening. Focus: the cholinergic support, exercise, omega-3, and ADHD treatment if indicated, with 4 to 6 weeks to replace nicotine's effect naturally. Belonging: the smoke break was a social ritual, so schedule non-smoking social time, walk with colleagues, and find people who do not smoke. Mood: 5-MTHF, exercise, bupropion, and psychiatric care.

Turn to: Supp. Ch. 22 §6 (the functional replacement map). Centurian Paper C-28 (The Recast). Compendium Protocol 19 (The Body in Motion), Protocol 29 (The Peacetime Paradox), Protocol 04 (Meeting Alternatives).

Step 9 — Body recovery (from week 1)

The Kernel's recovery timeline: blood pressure and heart rate normalize within 20 minutes; carbon monoxide clears in 12 hours; circulation and lung function improve within two weeks; heart disease risk halves within a year; stroke risk falls to a non-smoker's within five years; lung cancer risk halves within ten. Weight: the Kernel says 4 to 8 pounds is expected and metabolically normal, mostly in the first three months, and that a health trade-off strongly favors quitting. Exercise is its main tool, and a GLP-1 drug is an option to discuss if weight fear is the barrier. Monitoring: spirometry if you have breathing symptoms, blood pressure and lipids, a dental check, a thyroid check if symptoms, and lung cancer CT screening for heavy smokers (20 or more pack-years) aged 50 to 80.

Turn to: Supp. Ch. 22 §4.4 (weight gain management), §4.6 (pulmonary recovery), §8.1 (medical monitoring in nicotine recovery). Compendium Protocol 19 (The Body in Motion).

Step 10 — The long game (Months 3+, Year 1 to Year 10)

The Kernel says relapse risk stays raised for twelve months, especially at emotional stress points, so keep the craving interrupt practiced, and that the great majority of people who are still quit at twelve months stay quit permanently. Continue medication as your prescriber advises. Full Inventory is a structured 180-day plan, and Amends to Self puts the person who lived through it first. Navigation after the first year shifts from repair to stewardship. Section 4 shows how. Standing tools: Supp. Ch. 44 (The Transplant: redirect the devotion and daily structure the pattern required into a practice that grows). Supp. Ch. 6 (Stay Non-Addicted) and Compendium Protocol 02 (Behavioral Addictions, with its "Mask Change" caution on addiction transfer). Compendium Protocol 13 (The Pharma Trap). Supp. Ch. 38. Supp. Ch. 5, Step 6 (a weekly AI check-in profile, a reasoning tool and never a provider). Peer support the Kernel names: Nicotine Anonymous (nicotineanonymous.org).

Turn to: Supp. Ch. 22 §7 (long game: months 3 to 12) and §8.2 (resources). Supp. Ch. 42 (Full Inventory). Supp. Ch. 43 (Amends to Self). Centurian Paper C-28 (The Recast). Compendium Protocol 24 (Returning to Work), Protocol 25 (The Open Door). Supp. Ch. 51 (Family & Support Network Guide): give it to the people who love you.

4. How navigation changes at Years 3, 5, and 10

Shading shows how much attention each track needs. Darkest is primary focus, then active, then maintenance. White cells with gray text are standing safeguards: low effort, never dropped. Numbers in brackets refer to the shifts listed below the table. The Kernel's nicotine timeline ends at about 12 months, so later years are projection.

Track	Months 0–24 (foundation)	Year 3 (consolidate)	Year 5 (build out)	Year 10 (steward)
Safety and medication	MAT started; quit date set	Off MAT; lapse plan on file [1]	Tell prescribers smoking history	One cigarette restarts it [7]
Biology and genome	CHRNA5, CYP2A6; COMT, MTHFR	Retest labs; step stack to upkeep [2]	Prescriber card: CHRNA5, CYP2A6	Re-check with new meds and age
Cues and rituals	Habit loops cut; 3-minute rule	Cues fainter; social plans set	Triggers shift: stress, grief [5]	Same plan, rehearsed
Dopamine and mood repair	Move daily; 5-MTHF, choline	Exercise is the replacement [3]	Mood and focus steady	Movement kept, daily
Lungs and body checks	Spirometry, BP; weight expected	Lungs recovering; screening if due	Screening kept; dental, BP	Screening kept, if eligible
Underlying condition	Mood, ADHD plan; before quit day	Treatment holds; no nicotine needed [4]	Plan reviewed yearly	Annual review; meds cross-checked
Belonging and Manning	Purpose: first seeds only	New break rituals; belonging kept	Manning: quit coach, peer [6]	Mentor or run a group

The seven shifts

1. **Year 3, you are off medication, with a lapse plan on file.** The Kernel runs medicine for at least 12 weeks and says relapse risk stays raised for a year (Supp. Ch. 22 §7). By year 3 most people are off it. Keep a written plan for a lapse: call your prescriber, restart replacement, do not wait for "a fresh Monday." Bring it up if a medication is ever restarted.
2. **Year 3, the stack moves from building to upkeep.** Retest labs (Supp. Ch. 5 Step 1a) and step down toward maintenance. The Trinity chapter says supplements are taken until stable, then tapered and resumed if the system destabilizes; Main Book Ch. 2 treats MTHFR support as maintenance, not cure. Step down to maintenance, not to zero.
3. **Year 3, exercise is the replacement.** The Kernel calls daily aerobic exercise the most impactful behavioral intervention beyond medicine (Supp. Ch. 22 §7). By year 3 it should be the way your dopamine and stress are handled, and not a quit-year project.
4. **Year 3, treatment holds and nicotine is not needed.** The Kernel says the psychiatric condition needs a non-tobacco management strategy (Supp. Ch. 22 §7). By year 3, treatment for depression, ADHD, or anxiety should be doing what

tobacco did, with the plan reviewed by your clinician. This shift applies a Kernel rule at a timing chosen for this guide.

5. **Year 5, triggers shift to stress and grief.** The Kernel names stress as the most common cause of relapse (Supp. Ch. 22 §5). As habit cues fade, a loss, a crisis, or a period of high stress is the exposure. Keep the 3-minute interrupt and a replacement plan. This shift is extrapolation.
6. **Year 5, Manning.** This is the Trinity's third stage (Supp. Ch. 2). This is extrapolation: peer support and quit coaching, which the Kernel's resources (a quitline, Nicotine Anonymous) suggest and which draws directly on your experience of what worked.
7. **Year 10, one cigarette restarts it.** The Kernel calls the rule pharmacological reality (Supp. Ch. 22 §5), and it does not expire. Keep the interrupt, tell prescribers your smoking history, and keep lung screening if you are eligible.

What is sourced and what is extrapolated. *Shifts 3 and 7 rest directly on Kernel text. Shifts 1, 2, and 4 apply Kernel rules at a timing chosen for this guide. Shifts 5 and 6 are extrapolations. The Kernel's detailed nicotine timeline ends at about 12 months.*

5. What outcome to expect

The short version

If you do the route above, with the medication and psychiatric plan first, the genome guiding choices, a quit date supported by combination therapy, and the biological and natural architecture built, this is the outcome the Kernel projects:

- **The first days are the hardest.** The first 72 hours are the most acute and week 1 the hardest. After week 2 the physical withdrawal has largely settled.
- **Weeks 2 to 12 are behavioral.** Cravings peak in 3 to 5 minutes, and medicine runs at least 12 weeks.
- **Months 3 to 12 are the risk window.** Relapse risk stays raised for a year, especially at emotional stress points, and most people who are still quit at 12 months stay quit.
- **The body recovers on a known timeline.** From blood pressure in 20 minutes to halved lung cancer risk in ten years.
- **By years 3 to 5 the work is maintenance and building. By year 10 you are a steward,** carrying a small set of standing safeguards.

The Kernel does not promise a single attempt will work. It states that many people need combination medicine, that weight gain is expected, and that psychiatric conditions must be managed alongside.

Milestones, in order

Milestone	When	Expected outcome	Source	Basis
Plan and quit date	Weeks −2 to 0	Prescriber chosen. Varenicline or bupropion started a week before the quit date. Replacement ready. Psychiatric plan in place.	Supp. Ch. 22 §3.2, §7	Kernel projection
Acute window	First 72 hours; week 1	The most acute period and the hardest week. Cravings peak in 3–5 minutes. Use replacement rescue.	Supp. Ch. 22 §5, §7	Kernel projection
Physical withdrawal settles	After week 2	Physical withdrawal largely resolved. The remaining work is behavioral and psychological.	Supp. Ch. 22 §7	Kernel projection
Sleep and receptors	Weeks 2–6	Sleep fragmentation and vivid dreams settle in 2–4 weeks. Receptor systems substantially recover in about 4–6 weeks.	Supp. Ch. 22 §4.2, §4.5	Kernel projection
Medication course	Weeks 0–12	Varenicline and bupropion are 12-week courses. Weight gain of 4–8 lbs, mostly in the first 3 months.	Supp. Ch. 22 §4.4, §7	Kernel projection
Body recovery	Minutes to 10 years	Blood pressure in 20 minutes; CO clears in 12 hours; circulation in 2 weeks; heart risk halved in 1 year; stroke risk normal in 5 years; lung cancer risk halved in 10.	Supp. Ch. 22 §4.6	Kernel projection
Risk window	Months 3–12	Relapse risk stays raised for a year, especially under stress. Most people quit at 12 months stay quit.	Supp. Ch. 22 §7	Kernel projection
Steward phase	Years 3–10	Off medication with a lapse plan. Exercise and treatment carry the load. Lung screening if eligible. Standing safeguards.	Section 4 of this guide	Extrapolated

The Kernel's own 12-month numbers for one nicotine profile

Supplemental Chapter 2 gives projected outcomes at 12 months for an adherent protocol compared with standard treatment. Case 13 is a 55-year-old who has smoked since 17 and quit-attempted 11 times, always relapsing within three months, on patches, gum, and varenicline. He feels sharper and calmer when he smokes. His profile is COMT Val/Val (Warrior), likely high MAOA activity, a possible CYP2A6 variant, and unknown MTHFR. The Kernel says the 11 failures were pharmacogenomic mismatches, not moral ones.

Case	Measure	Kernel protocol	Standard treatment
Case 13	12-month abstinence with bupropion, biological support, and exercise	67%	20%
Case 13	Significant withdrawal symptom reduction at Week 4	74%	30%

Case	Measure	Kernel protocol	Standard treatment
Case 13	Mood and motivation maintained at Month 3 after quitting	70%	25%
Case 13	No return to daily smoking at 12 months	65%	22%

How to read these numbers. *The Kernel describes them as archetype projections, "probability estimates" for an adherent, biologically confirmed 12-month protocol, drawn from cited studies. Its own baseline is 15 to 25 percent at 12 months with any single intervention, and about 30 to 35 percent for bupropion plus counseling. They are not guarantees, and the Main Book states that it is not reporting a randomized controlled trial of the Kernel itself. The case protocol centers on bupropion and prior dopamine support.*

What changes the outcome

- **Trying it on willpower alone,** when the Kernel says medicine roughly doubles or triples your odds.
- **Starting medicine on the quit date** instead of a week before, for varenicline and bupropion.
- **Using single nicotine replacement** when combination replacement is more effective, or a medicine as an either-or when both can be used together.
- **Removing tobacco before the underlying condition is managed:** depression, ADHD, anxiety, or psychosis.
- **Ignoring the ritual.** The coffee, the meal, the break, and the stress reflex are conditioned and need their own change.
- **The "just one" moment.** The Kernel says one cigarette restarts the conditioning.
- **Weight fear** used as a reason to keep smoking.
- **Vaping or pouches as an open-ended substitute.** The Kernel says a cessation tool needs an end date.
- **A lapse.** The Kernel treats it as information, not judgment (Protocol 21). Call your prescriber or quitline, restart replacement, and treat it as a set-back, not the end.

How to read the evidence behind the outcomes

The Main Book marks claims with an Evidence Tier: Established, Probable, Emerging, Author/System Experience, and Controversial or Mixed. This guide's reading: the effectiveness of varenicline, combination nicotine replacement, and bupropion, and the CHRNA5 and CYP2A6 effects, are well supported, and the direction of the Kernel's multipliers matches the wider literature, though the exact figures are the Kernel's. The claim that varenicline plus a patch does best is supported but the evidence is thinner, and GLP-1 drugs for smoking are still investigational. The Kernel's statement that Allen Carr's Easyway is "the most evidence-supported bibliotherapy approach" is stronger than the evidence, and I would treat it as one optional resource among others. The supplement stack, the choline and huperzine layer, the COMT-based medication matching, and the years 3 to 10 trajectory sit lower on that scale, so bring them to your clinician as questions, not as facts.

Take these to your prescriber

- An honest account of your use: which products, how much, how long, how soon after waking, your past quit attempts and what happened, and any vaping or pouch use.
- Every medication you take, especially psychiatric drugs (clozapine, olanzapine, an antidepressant), any seizure history, an eating disorder, or alcohol use, so bupropion, varenicline, and clearance changes can be judged.
- Your mood and psychiatric history and how you felt on past quit attempts, and a request for a plan for depression, ADHD, or anxiety before the quit date.
- Your CHRNA5, CYP2A6, COMT, and MTHFR results if you have them, and a request for combination therapy (varenicline plus a patch) if appropriate.
- Questions about pregnancy or breastfeeding, weight gain and GLP-1 medicines, and, if eligible (heavy smoking history, aged 50 to 80), lung cancer CT screening.